September 1, 2006

My Support & Spending Plan

This Plan belongs to:

_____

Developing your Support & Spending Plan

Your goal is to submit a **Support and Spending Plan** which reflects your personal goals and needs AND assures you are able to live safely and successfully in the community within your allocated budget. There are several steps to developing a Support and Spending Plan. Below is a brief overview of each of the steps involved in completing this process. Detailed instructions for filling out each form listed in the steps below are also on the page preceding that form in the Support and Spending Plan template.

1. **FIRST STEP**: First, you should have already completed your **My Voice, My Choice Workbook**. Have your workbook available before you begin writing your **Support and Spending Plan**.

2. **SECOND STEP:** Create your **My Support Plan** pages. To create your **My Support Plan** pages you will need to refer back to the worksheets in your My Voice, My Choice Workbook. The worksheets will help you decide on goals that will allow you to get the things you want and need. Keep in mind that there is no one "correct" way to write a goal. Goals can be written as broad as "explore employment opportunities" or as specific as "learn how to use my QUEST card".

   Your My Support Plans will also identify whether someone will be providing support to you at no cost or whether Medicaid will be paying for the support. In many cases you may be able to do things yourself to accomplish your goal or it may be possible for you to get help for free from community organizations and natural supports. The more support you can find at no cost to you, the more money you will have available to put towards developing other goals or to save for a "rainy day".

3. **THIRD STEP**: Review your **My Health and Safety Plan** in your My Voice, My Choice workbook. If you listed health and/or safety issues at home, at work or in the community you must also create a My Support Plan page to go along with these health and/or safety issues. This will ensure supports are in place which address each of the identified risks.

4. **FOURTH STEP**: Develop **Back-Up Plans**. To decide which supports require a Back-Up Plan you must review all of your My Support Plan pages. If your health or safety would be in immediate jeopardy if a natural or paid support listed on a My Support Plan did not arrive at the scheduled time to provide the support, a back-up plan must be developed for that support. A back-up plan identifies three (3) other ways you could go about getting the help you need should a critical support not show. Use the **Back-Up Plan** form to create back-up plans for critical natural or paid supports listed on all of your My Support Plan pages.

5. **FIFTH STEP**: Complete your **My Spending Plan Worksheet**. Review the "Paid Supports" section of each of your My Support Plans. You will need to list each service, task or good that you are paying for in the section of the My Spending Plan Worksheet that corresponds to the type of support checked for the particular service, task or good. This sheet is also used to to identify who will provide the support, how often and at what cost.

6. **SIXTH STEP**: Fill out the **My Spending Plan Summary**. You will be transfering the "Total" associated with each type of support listed on your My Spending Plan Worksheet to this page.

7. **SEVENTH STEP**: Complete the **Support and Spending Plan Authorization** page. This is where you will transfer every paid support listed on your My Spending Plan Worksheets into the support category with the corresponding title. The total amount of money you are going to spend for services, tasks, or goods in a particular support category is also listed on this page.

8. **EIGHTH STEP**: Read, sign and date the **Choice and Informed Consent Statement**. This form states you agree with the Support and Spending Plan you are submitting, accept your responsibilities under the Self-Direction option and choose waiver services over institutional placement.

NOTE: For your convenience we have included ten (10) My Support Plan pages and three (3) Back-up Plan pages with this template. If you need more pages of a particular form then have been included, you will need to use your computer to cut and paste additional blank pages into the document. You can access the entire Support and Spending Plan document at the following website: www.selfdirection.idaho.gov.

SUPPORT AND SPENDING PLAN COVER SHEET

Instructions:

Step 1. Check either the "Initial Plan" or "Annual Plan" box. Only check the "Initial Plan" box if this is the first Support and Spending Plan you have completed as part of the Self-Direction option.

Step 2. Complete information on self, guardian (if applicable) and health care providers in the demographic section of the cover sheet.

Step 3. List the names of all individuals who were involved in helping develop the Support and Spending Plan in the section "People Who Helped Create This Plan". This list should include those individuals who may not have attended Person-Centered Planning meeting(s), but were involved in helping develop your plan.

SUPPORT AND SPENDING PLAN COVER SHEET

☐ Initial Plan ☐ Annual Plan	
Individual's Name:	
Address:	
City, State, Zip Code:	
Community Living Arrangement:	
Telephone number(s): Home: (208)	Cellular: (208)
Medicaid ID #:	
Date of Birth:	
Legal Guardian (if applicable):	
Address:	
City, State, Zip Code:	
Telephone number(s): Home: ( )	Cellular: ( )
Primary Care Provider:	Healthy Connections: ☐ Yes ☐ No
Specialist(s):	
Dentist:	

People who helped create this plan

Name:	Relationship to Participant:
Name:	Relationship to Participant:
Name:	Relationship to Participant:
Name:	Relationship to Participant:

Instructions:

Step 1. Complete "Individual Name" and "Medicaid ID #" lines at top of page.

Step 2. (Goal or Need box) List the goal or need the individual wants to achieve or accomplish in the upcoming plan year. There is no one "correct" way to write a goal. Goals can be written as broad as "explore employment opportunities" or as specific as "learn how to use my QUEST card".

Step 3. List the activities the individual is able to do on their own to reach their goal or meet their need.

Step 4. Identify what natural supports are available to help the individual reach their goal or meet their need and how often these natural supports will be able to provide this help.

Step 5. ("Paid Supports" section) Complete the boxes as follows:

- List the service, task or good needed to reach the goal or meet the need.
- Indicate the type of support being provided by the service, task or good by placing a checkmark (✓) in the box corresponding to the support (i.e. Personal Support, Job Support, etc.). Only checkmark one (1) type of support. Use the following definitions to determine which type of support best describes the service, task or good being purchased:

  - **PERSONAL**: Helps the individual maintain health, safety and basic quality of life.
  - **JOB**: Helps the individual secure and maintain employment or attain job advancement.
  - **TRANSPORTATION**: Helps the individual accomplish identified goals through gaining access to community services, activities and resources.
  - **LEARNING**: Helps the individual learn new skills or improve existing skills that relate to identified goals.
  - **RELATIONSHIP**: Helps the individual establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community.
  - **EMOTIONAL**: Helps the individual learn and practice behaviors consistent with goals and wishes while minimizing interfering behaviors.
  - **ADAPTIVE EQUIPMENT**: Equipment that meets a medical or accessibility need and promotes the individual's increased independence.
  - **SKILLED NURSING**: Intermittent or private duty nursing services which are within the scope of the Nurse Practice Act and are provided by a licensed professional nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho.

My Support Plan

Individual's Name: ___________________________ Medicaid ID # __________________________________

Goal or Need:

What activities will I be able to do myself to reach my goal or meet my need?	How often do I need to do these activities?

Who could help me reach my goal or meet my need that wouldn't have to be paid?	How often will they provide the support?

PAID SUPPORTS

Service, task or good needed	**Type of Support** ☑ only one box
	☐ Personal ☐ Emotional ☐ Job ☐ Skilled Nursing ☐ Transportation ☐ Relationship ☐ Learning ☐ Adaptive Equipment
	☐ Personal ☐ Emotional ☐ Job ☐ Skilled Nursing ☐ Transportation ☐ Relationship ☐ Learning ☐ Adaptive Equipment
	☐ Personal ☐ Emotional ☐ Job ☐ Skilled Nursing ☐ Transportation ☐ Relationship ☐ Learning ☐ Adaptive Equipment
	☐ Personal ☐ Emotional ☐ Job ☐ Skilled Nursing ☐ Transportation ☐ Relationship ☐ Learning ☐ Adaptive Equipment

IMPORTANT: If your health or safety would be in immediate jeopardy if a natural or paid support listed on this My Support Plan did not arrive at the scheduled time to provide the support, a back-up plan must be developed for that support. A back-up plan identifies three (3) other ways you could go about getting the help you need should a critical support not show. Use the **Back-Up Plan** form to create back-up plans.

My Back-up Plan

Individual's Name: _____ Medicaid ID # _____

If your health or safety would be in immediate jeopardy if a natural or paid support listed on any of your My Support Plans did not arrive at the scheduled time to provide the support, a back-up plan must be developed for that support.

For any supports you identify that require a Back-up Plan, first list the "Goal or Need" associated with the support, then state the support that needs to be provided, followed by three (3) other ways you could get the help. Please enter this information in the spaces provided below

Goal or Need:
Support that needs to be provided:
Back up plans: 1.
2.
3.

Goal or Need:
Support that needs to be provided:
Back up plans: 1.
2.
3.

Goal or Need:
Support that needs to be provided:
Back up plans: 1.
2.
3.

MY SPENDING PLAN WORKSHEET

Instructions:

Step 1. Complete "Individual Name" and "Medicaid ID #" lines at top of page.

Step 2. ("Support Broker" column) Enter the name of your Support Broker.

Step 3. ("Hours per year" column) Enter the maximum number of hours you will employ your Support Broker to provide services during the upcoming Plan Year.

Step 4. ("Cost per hour" column) Enter the hourly rate you will pay your Support Broker during the upcoming Plan Year. This hourly rate cannot exceed $18.72/hour.

Step 5. ("Annual cost" column) Multiply the total number of hours by the hourly cost to calculate your annual cost for Support Broker services.

Step 6. Select one of your **My Support Plan** pages. Refer to the **PAID SUPPORTS** section. For each service, task or good listed under the Paid Supports section of your My Support Plan, list that service, task or good in the section that corresponds with the "Type of Support" checked (☑) for that particular service, task or good on the My Support Plan.

Step 7. ("Name of Person, Agency or Vendor providing the support" column) Enter the name of the person, agency or vendor who will be providing the identified service, task or good.

Step 8. ("Number of hours/items needed per year" column) Enter the maximum number of hours or items needed of that service, task or good during the upcoming Plan Year.

Step 9. ("Cost per hour/items" column) List in this column the hourly or per item cost for the service, task or good. *IMPORTANT: If you are hiring a person to provide hourly services, you will need to add an additional 6.2% to the hourly wage you want to pay your service provider before putting the hourly cost in this column. The additional 6.2% is the employer share of Social Security withholding tax that you will have to pay to the Federal Government as an employer under the Self-Directed Community Supports option.*

Step 10. ("Annual cost" column) Multiply the total number of hours or items by the hourly or per item cost to calculate the annual cost of the service, task or good.

Repeat Steps 6 -10 for every PAID service, task or good listed on all of your "My Support Plan" pages. Calculate the "Total" for each type of support (i.e. Personal, Job, etc.) by adding together the annual cost(s) of all of the service(s), task(s) or good(s) listed.

My Spending Plan Worksheet

Individual's Name: _____ Medicaid ID #: _____

Support Broker: Advocate for the individual and is hired by individual to provide Support Broker services.

Name & Address	Hours per year		Cost (per hour)		Annual Cost
		x		=	

Total= _____

Personal Support: Helps the individual maintain health, safety and basic quality of life.

Service, Task or Good	Name of Person, Agency or Vendor providing the support	Number of hours/items needed per year		Cost per hour/item		Annual Cost
			x		=	
			x		=	
			x		=	
			x		=	
			x		=	
			x		=	
			x		=	
			x		=	

Total= _____

My Spending Plan Worksheet

Individual's Name: _____ Medicaid ID #: _____

Job Support: Helps the individual secure and maintain employment or attain job advancement.

Service, Task or Good	Name of Person, Agency or Vendor providing the support	Number of hours/items needed per year		Cost per hour/item		Annual Cost
			x		=	
			x		=	
			x		=	
			x		=	

Total= _____

Transportation Support: Helps the individual accomplish identified goals through gaining access to community services, activities and resources.

Service, Task or Good	Name of Person, Agency or Vendor providing the support	Number of hours/items needed per year		Cost per hour/item		Annual Cost
			x		=	
			x		=	
			x		=	
			x		=	

Total= _____

My Spending Plan Worksheet

Individual's Name: _____ Medicaid ID #: _____

Learning Support: Helps the individual learn new skills or improve existing skills that relate to identified goals.

Service, Task or Good	Name of Person, Agency or Vendor providing the support	Number of hours/items needed per year		Cost per hour/item		Annual Cost
			x		=	
			x		=	
			x		=	
			x		=	
			x		=	

Total= _____

Relationship Support: Helps the individual establish and maintain positive relationships with immediate family members, friends, spouse or others in order to build a natural support network and community.

Service, Task or Good	Name of Person, Agency or Vendor providing the support	Number of hours/items needed per year		Cost per hour/item		Annual Cost
			x		=	
			x		=	
			x		=	
			x		=	

Total= _____

My Spending Plan Worksheet

Individual's Name: _____ Medicaid ID #: _____

Emotional Support: Helps the individual learn and practice behaviors consistent with goals and wishes while minimizing interfering behaviors.

Service, Task or Good	Name of Person, Agency or Vendor providing the support	Number of hours/items needed per year		Cost per hour/item		Annual Cost
			x		=	
			x		=	

Total= _____

Skilled Nursing Support: Intermittent or private duty nursing services which are within the scope of the Nurse Practice Act and are provided by a licensed professional nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho.

Service, Task or Good	Name of Person, Agency or Vendor providing the support	Number of hours/items needed per year		Cost per hour/item		Annual Cost
			x		=	
			x		=	

Total= _____

Adaptive Equipment: Equipment that meets a medical or accessibility need and promotes the individual's increased independence.

Service, Task or Good	Name of Person, Agency or Vendor providing the support	Number of hours/items needed per year		Cost per hour/item		Annual Cost
			x		=	
			x		=	
			x		=	

Total= _____

Instructions:

Step 1. Complete “Individual Name” and “Medicaid ID #” lines at top of page.

Step 2. Refer to the “My Spending Plan Worksheet” pages. Transfer the “Total” from each individual section of the “My Spending Plan Worksheets” to the My Spending Plan Summary sheet. (i.e. totals for Support Broker, Personal Support, Job Support, etc.)

Step 3. Add together the totals for Support Broker, Personal Support, Job Support, Transportation Support, Learning Support, Relationship Support, Emotional Support, Skilled Nursing Support, and Adaptive Equipment to calculate your Community Support Total.

My Spending Plan Summary

Individual's Name: _____ Medicaid ID # _____

Support Broker Total	$_____
Personal Support Total	$_____
Job Support Total	$_____
Transportation Total	$_____
Learning Support Total	$_____
Relationship Total	$_____
Emotional Support Total	$_____
Skilled Nursing Support Total	$_____
Adaptive Equipment Total	$_____
Community Supports Total	= $_____
Fiscal Employer Agent	+ $_____
Grand Total	= $_____

SUPPORT AND SPENDING PLAN AUTHORIZATION

Instructions:

Step 1. Complete "Individual Name" and "Medicaid ID #" lines at top of page.

Step 2. Enter the "Community Supports Total" from your My Spending Plan Summary page to the **"**Community Supports (CS) Total" line on this page.

Step 3. Enter the "Fiscal Employer Agent Total" from your My Spending Plan Summary page to the "Fiscal Employer Agent (FEA)" line on this page.

Step 4. Add together the "Community Supports (CS) Total" and the "Fiscal Employer Agent (FEA)" to calculate the "Grand Total". Enter this dollar amount on the "Grand Total (CS + FEA)" line.

Step 5. In the "gray" shaded box on the upper right hand side of the page, enter the Annual Medicaid Budget you were given at the time eligibility was determined. Refer to your eligibility approval letter for this information.

Step 6. Transfer the "Support Broker Total" from your My Spending Plan Worksheet onto the "Support Broker Total" line of this page.

Step 7. Transfer every service, task or good listed on your My Spending Plan Worksheets into the support section with the corresponding title.

Step 8. Transfer the "Total" from each of the support sections of your My Spending Plan Worksheets onto the "Total" line with the corresponding title.

Support and Spending Plan Authorization

Individual's Name: _____

Medicaid ID # _____

Date of Approval: _____

Plan Approved By: _____

_____
Regional Medicaid Services Signature

Annual Medicaid Budget $_____

Community Supports (CS) Total $_____

Fiscal Employer Agent (FEA) $_____

Grand Total (CS +FEA) $_____

Support Broker Total: _____

Personal Support
(Services, tasks and goods)

_____ _____

_____ _____

_____ _____

Total:_____

Job Support
(Services, tasks and goods)

_____ _____

_____ _____

_____ _____

Total:_____

Transportation Support
(Services, tasks and goods)

_____ _____

_____ _____

_____ _____

Total:_____

Learning Support
(Services, tasks and goods)

_____ _____

_____ _____

_____ _____

Total:_____

Relationship Support
(Services, tasks and goods)

_____ _____

_____ _____

_____ _____

Total:_____

Emotional Support
(Services, tasks and goods)

_____ _____

_____ _____

_____ _____

Total:_____

Skilled Nursing Support
(Services, tasks and goods)

_____ _____

_____ _____

Total:_____

Adaptive Equipment
(Services, tasks and goods)

_____ _____

_____ _____

Total:_____

Choice and Informed Consent Statement

Instructions: Read, sign and date the Choice and Informed Consent Statements.

Individual's Name: _____ Medicaid ID #: _____

Choice Statement:

I have reviewed the services contained in this Support and Spending plan, and I choose to accept this plan and understand my responsibilities under the Self-Direction option of the Developmental Disabilities waiver.

_____ _____ _____ _____
Individual's Signature Date Guardian Signature (if applicable) Date

Informed Consent Statement:

I have been informed of and understand my choice of waiver services. I choose to receive waiver services rather than to accept placement in an ICF/MR. I understand that I may at any time, choose facility admission.

_____ _____ _____ _____
Individual's Signature Date Guardian Signature (if applicable) Date